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| **Department of Veterans Affairs** | **REQUEST FOR PHYSICAL EXAMINATION** |
| NOTE; Shaded items are not to be completed by originator. |
| 1. NAME | 2. FILE NUMBER | 3. SOC. SEC. NO. | 4. DATE OF BIRTH | 5. SEX | 6. PERIOD OF SERVICE | 7.CONTROL DATE |
|  | EOD | RAD |  |
| 8A. FIRST NAME-MIDDLE INITIAL-LAST NAME OF VETERAN | 8B. ADDRESS OF VETERAN*(STREET, CITY, STATE AND ZIP CODE)* | 8C. DAYTIME TELEPHONE NO. OF VETERAN *(INCLUDE AREA CODE)* |
| 9. REGIONAL OFFICE ADDRESS |
| 10. RECEIVING STATION ONLY |
| A. DATE OF RECEIPT | B. DATE SCHEDULED OR AUTHORIZED | C. DATE COMPLETED | D. PLACE OF EXAMINATIONCLINIC FEE OTHER STATION |
| E. NAME OF FEE EXAMINER OR OTHER STATION |
| 11. PRIORITY OF EXAMINATION (CHECK APPROPRIATE BOX(ES))TERMINAL POW ORIGINAL (S.C.)REVIEW OTHER(SPECIFY) |  | ORIGINAL (N.S.C.) | INCREASED OR REOPENED |
| 12. PLEASE CONDUCT:A. A COMPLETE GENERAL MEDICAL EXAMINATION WITH SPECIAL ATTENTION TO DISABILITIES LISTED IN ITEM 13 B. AN EXAMINATION LIMITED TO DISABILITIES LISTED IN ITEM 13 |
| 13. REMARKS *(LIST DIAGNOSES OR SYMPTOMS FOR WHICH EXAMINATION IS REQUIRED)* |
| 14. CLAIMANT REPRESENTED BYAL AMVETS DAV JWV MOPH | PVA | VFW OTHER *(SPECIFY)* |  |
| 15. DATE | 16. SIGNATURE OF AUTHORIZING OFFICIAL | 17. SYMBOL AND BOARD NO. |

VA FORM OCT. 2003

21-2507